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ABSTRACT

This paper presents guidelines for developing programs for the early detection of physical, behavioral, and educational problems of young children. The purpose, definitions of terms and roles, procedures for organization and implementation of the screening programs are briefly outlined. The paper consists primarily of supporting information: (1) post-screening activities and resources, including procedures for follow-through, national, state and local resource directories of services for children, and follow-up activities designed for gross and fine motor development, speech and language stimulation, and personal and social development; (2) a survey of available screening instruments and procedures which provides information helpful in determining which instruments would be most appropriate for the local situation; (3) procedural guidelines for vision and hearing screening; and (4) brief descriptions of four model training programs currently in operation in Missouri. (ED)

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GUIDELINES FOR AN EARLY CHILDHOOD SCREENING PROGRAM

For Children Ages Three Through Five

PS 007272

MISSOURI STATE DEPARTMENT OF EDUCATION

1973

Arthur L. Mallory
Commissioner of Education

FOREWORD

Dear Colleague:

These guidelines have been written to assist the schools and other agencies serving children to coordinate their efforts in identifying the needs of children at an early age.

A screening program is intended as a means of looking at all young children in a broad developmental sense to gain a better understanding of their diversity and variability. It also serves to detect physical, behavioral, and educational problems that may interfere with a child's success in school.

It is my hope that this publication will be helpful to all persons concerned with improving educational opportunities and services for young children.

Commissioner of Education

ACKNOWLEDGMENTS

These guidelines have been written by the Task Force on Early Childhood Screening of the Advisory Committee on Early Childhood Development, in cooperation with the State Department of Education. Appreciation is expressed to the following task force members who gave of their time and professional expertise to develop these guidelines:

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ORGANIZATIONAL GUIDELINES FOR AN EARLY CHILDHOOD SCREENING PROGRAM

Preface:

In accordance with HB 474, enacted by the 77th Session of the Missouri Legislature and signed by the Governor on August 1, 1973, every child is guaranteed the right to an education that is appropriate to his developmental needs. To assist the schools in identifying the needs of children at an early age a task force was established by the State Department of Education to develop guidelines for early childhood screening.

I. Purpose of Early Screening

The purpose of early screening of children ages three through five is to identify suspected physical, behavioral and educational problems that may interfere with their ability to achieve success in school. A screening program, which should be offered to all children, is also intended to gain better understanding of the diversity and variability of their developmental levels.

II. Definition of Screening

Screening is defined as the use of relatively simple devices administered on initial contact with the population which are valid and reliable in terms of determining relative normalcy. Interventions initiated on the basis of the test results should lead to a significantly different effect than if deferred to the time when the problem would normally be identified.

III. Reasons for Screening

The primary reasons for screening are:

A. To develop public awareness of the need for early identification and treatment of suspected physical, behavioral and educational problems.

B. To assist parents and teachers in becoming more knowledgeable of the variability in early childhood development.

C. To plan educational programs of a developmental nature for children so identified to be carried out at home, at school, in the community that will enhance each child's capability of realizing his full potential for development.

IV. Procedures for Organizing an ESP (hereinafter representing EARLY SCREENING PROGRAM)

A. School/Community Cooperation

Joint efforts between a local school system and community groups and agencies facilitates an ESP. A local school system should either initiate the program or be involved in it on a cooperative basis.

B. The Role of the Primary Advocates, the Initiators of an ESP

1. The primary advocates in a locale should consist of a team of at least two persons: one educator in the school system designated by the superintendent and one community person.

2. The role of the primary advocates is to serve as an initial stimulus to create an interest in ESP in the community, to seek financial support, to begin to recruit volunteers and to obtain such professional consultation as seems desirable. (See IV. D.)

C. The Role of the Implementor

1. The primary advocates should select an implementor for the ESP.
2. The implementor should be part of a funded structure, preferably holding a paid position with the local school system.
3. The implementor will administer the ESP, being knowledgeable of community resources, including the activities and services of various organizations, and being sensitive to the concerns of community power groups. The implementor will provide for public relations activities, volunteer recruitment and training, scheduling, the mechanics of screening and follow-through.
4. The implementor should be skilled in administration. How many of the skills he or she will have, as listed under 3. above will determine how much additional training and help he or she will need.
5. If the implementor's skills do not include ability to report screening results to parents, it will be necessary to seek consultation from a qualified person to carry out this task. A person qualified to report the screening results should be one of the following: school psychologist; clinical psychologist; psychiatric social worker; guidance counselor; learning disabilities specialist or one experienced and previously trained in the administration and reporting of the screening tools to be used.

6. The reporting of screening results by the implementor, or his designated consultant, should not leave the impression that an in-depth diagnostic evaluation of a child has been made on the basis of screening results. Rather the implementor, or his designated consultant, should inform the parent or legal guardian of any findings noticed in the screening protocol which should be evaluated further by testing of a diagnostic nature.

D. Consulting Services

1. Workshops concerning an ESP are to be given in each of the eleven supervisory districts of the state for personnel designated by the superintendent to represent their districts. The workshops are to be conducted by State Department of Education personnel assisted by members of the Task Force on Early Childhood Screening. The workshops shall be designed to clarify and discuss the ESP guidelines and the ESP models.

2. Future consideration should be given to the establishment of a corps of regional consultants from the State Department of Education to assist the local school districts in coordinating resources and in implementing screening and follow-up procedures.

V. Procedures for Implementing an ESP

A. Public Relations Aspects

1. In publicizing and conducting an ESP a positive approach is extremely important. Early screening should be presented as a means of looking at the needs of all young children in

a broad developmental sense that can lead to better educational opportunities for them.

2. Community groups and agencies that should be informed and involved in an ESP include:
    a. Pediatricians, physicians, hospitals, well-baby clinics, mental health agencies, extension and child welfare services and other professionals and agencies concerned with the health and welfare of young children.
    b. Head Start and other public and private programs providing child care and early education.
    c. Church and community clubs and organizations that provide volunteer services; parent groups such as United Cerebral Palsy Association, Missouri Association for Retarded Children, Missouri Association for Children with Learning Disabilities.
3. Publicity regarding an ESP should utilize all public information media including:
    a. Notes and flyers sent out from the schools.
    b. Notices in bulletins and newsletters from churches and other community organizations.
    c. Parent meetings to inform parents of the purpose and nature of an ESP.
    d. Publicity on dates, times and locations, via newspapers, radio and TV.

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B. Procedures and Resources for Follow-Through

1. A directory of all available resources for diagnosis and follow-up should be developed at the local level.
2. Further evaluation of those children found to have marked developmental variability should be initiated at the local level prior to referral outside the community.
3. See Appendix A for a directory of resources, procedures for referral and suggested follow-up learning activities for home and school use.
4. It is suggested that the State Department of Education build in some empirical research of varied ESP results, selecting samples of urban, rural and small town population throughout the state for study. Statistical information would include: number and types of problems detected, types of referrals made, services used and types of educational treatment that resulted.

C. Determination of Program Structure

1. The implementor, with assistance from other professionals, should select the screening tools to be used. See Appendix B for a survey of appropriate screening instruments, including procedures for vision and hearing screening.
2. The implementor should arrange for dates, locale, personnel and physical set-up for screening and reporting to parents.

D. Training Program for Administration of Screening Tools

1. Screening tools may be administered by volunteers as well as professionals. Local needs and availabilities will determine

which personnel are involved. In some instances both professionals and volunteers may be administering the tools.

2. Four models of training programs are found in Appendix C, namely: the Kansas City Model, as carried out by Southeastern Jackson County Mental Health Association; the St. Louis County Health Department Model; the Miriam School Model; the Brookfield School District Model. The Kansas City Model is an outreach kind of model, that may prove appropriate to communities having fewer professional resources available. The St. Louis Model is an agency-based model, having the availability of many professional resources. The Miriam School Model focuses on training local school personnel. The Brookfield Model represents a screening program implemented by a school district serving a small town and surrounding rural area.
3. If the Denver Developmental Screening Test is used, a training film is available for rental from the publisher at $45.00 a week. Training procedures can be observed by prior arrangement with the Southeastern Jackson County Mental Health Association and the St. Louis County Health Department, Division of Mental Health.

E. Parent Relations

1. An important aspect of an ESP is the initial contact with the parent before or at the time of screening. Various approaches to parent contact are described under each program model in Appendix C.

2. Reporting to parents on the screening results is equally important.

   a. The implementor, if he is not so qualified, must be able to obtain consulting services of someone qualified for reporting, as previously stated, i.e.: school psychologist, clinical psychologist, psychiatric social worker, guidance counselor, learning disabilities specialist or a person trained in administration and interpretation of results of the screening tool(s) being used in the ESP.

   b. The results of each child's screening tests should be reported to the parents or legal guardians. The results of screening for children identified as essentially normal could be reported through written communication, with opportunity given for parent conference if desired. It should be emphasized that the child should be checked again in one year. This could be approached in a manner similar to dental check-ups.

   c. The reporting of screening results for those children identified as having a possible problem should be made in person. Again it is emphasized that such reporting by the implementor or his designated consultant should be structured so as not to leave the impression with the parent that a diagnosis has been made, but that the screening tools employed have indicated the need for further testing of a diagnostic nature to determine if a problem actually exists. Sensitive reporting of all tests results is essential to maintain good public relations.

d. A primary purpose for reporting to parents on screening results should be to involve them as fully as possible in the follow-up educational and developmental processes in the home, school and community. See Appendix A for suggested follow-up learning activities.

Appendix A, Part 1

PROCEDURES FOR FOLLOW-THROUGH

Procedures for further evaluation and follow-through for those children found to have marked developmental variability:

A. Implementor will have made available referral information to be used by self or personnel qualified for interpretation and follow-through.

B. Prior to referral outside of the community all local options should be investigated. Further evaluation will include one or more of the following: Medical reports, clinical diagnosis, appropriate testing by qualified school personnel, parent interview, other indicators of existing or potential educational handicapping conditions.

C. Following such evaluation, proper intervention for each child, based on information obtained through the evaluation, should be initiated. The kind of intervention will be dependent upon local or regional facilities and programs available.

D. During the intervention period, periodic evaluation of each child's progress should be made in order to identify those students who have not responded appropriately to the recommended procedures and to modify the intervention program accordingly.

Appendix A, Part 2

RESOURCE DIRECTORIES OF SERVICES FOR CHILDREN

The following list of resource directories is representative of those available at the national, state, and local levels describing services for children with special needs.

A. National Resource Directories

ORGANIZATION: American Speech and Hearing Association

ADDRESS: 9030 Old Georgetown Road, Washington, D. C. 20402

NAME OF DIRECTORY: "American Speech and Hearing Association Directory"

FEE: $7.00

BRIEF DESCRIPTION: A comprehensive Directory of Speech and Hearing professionals throughout the United States. Names are listed alphabetically, under state listings and city listings. There is also notation to show whether the person is an audiologist or speech pathologist. The listings are such that one can also find clinical settings in a certain geographical location.

ORGANIZATION: Council for Exceptional Children

ADDRESS: Information Center, 1411 South Jefferson Davis Highway, Suite 900, Arlington, Virginia 22202

NAME OF DIRECTORY: "A Selected Guide to Government Agencies Concerned with Exceptional Children"

FEE: No Charge

BRIEF DESCRIPTION: The pamphlet describes the special education instructional materials network (listing addresses and directors of the centers) and programs sponsored by the USOE, Bureau of Education for the Handicapped and other federal agencies.

ORGANIZATION: Council for Exceptional Children

ADDRESS: Information Center, 1411 South Jefferson Davis Highway, Suite 900, Arlington, Virginia 22201

NAME OF DIRECTORY: "A Selected Guide to Public Agencies Concerned with Exceptional Children"

FEE: No charge

BRIEF DESCRIPTION: This pamphlet gives names, addresses and brief scope descriptions of more than 80 organizations and associations throughout the nation.

ORGANIZATION: National Association for Mental Health

ADDRESS: 10 Columbus Circle, New York, New York 10019

NAME OF DIRECTORY: "Directory of Facilities for Mentally Ill Children in the United States"

FEE: $2.50

BRIEF DESCRIPTION: Includes service information, capacity, geographic eligibility, costs and diagnostic consideration. A state by state directory of mental health services.

ORGANIZATION: S. Porter Sargent, Publishers

ADDRESS: 11 Beacon Street, Boston, Massachusetts 02108

NAME OF DIRECTORY: "Directory for Exceptional Children"

FEE: Not known

BRIEF DESCRIPTION: Provides a directory of national referral sources which can be used to identify a number of organizations which provide various services. Examples of resources included are: a state by state listing of schools for the emotionally distrubed and socially maladjusted; services for the blind and partially sighted; psychiatric and guidance clinics; services for orthopedic and neurological handicapped; speech and hearing clinics.

ORGANIZATION: United States Government

ADDRESS: Superintendent of Documents, U.S. Printing Office, Washington, D.C. (Stock No. 1791-0176)

NAME OF DIRECTORY: "Serving Children with Special Needs"

FEE: $.75

BRIEF DESCRIPTION: A practical guidebook for those planning to include handicapped children in their programs. Includes staffing and staff training, working with parents, program ideas.

B. State Resource Directories

ORGANIZATION: Division of Health

ADDRESS: Office of Maternal and Child Health, Missouri Division of Health, Jefferson City, Missouri 65101

NAME OF DIRECTORY: "A Program for Children with Communication Disorders"

FEE: No charge

BRIEF DESCRIPTION: Lists 28 clinics around the state of Missouri that offer help for those children who have speech and/or hearing disorders. The booklet outlines objectives, detection, referral, eligibility, evaluation, medical care and therapy and habilitation.

ORGANIZATION: Division of Mental Health

ADDRESS: Information Office, 722 Jefferson Street, Jefferson City, Missouri 65101

NAME OF DIRECTORY: "Missouri's Public Mental Health Mental Retardation Services"

FEE: No charge

BRIEF DESCRIPTION: Lists facilities in the state of Missouri that offer help for those with mental health and mental retardation problems.

ORGANIZATION: Division of Welfare

ADDRESS: Department of Public Health and Welfare, Broadway State Office Building, Jefferson City, Missouri 65101

NAME OF DIRECTORY: "Assistance for Needy Children in Missouri" (Informational Leaflet No. 2)

FEE: No charge

BRIEF DESCRIPTION: Explains the concept of aid to dependent children, who is eligible, amount of benefits available and ways to apply.

ORGANIZATION: Division of Welfare

ADDRESS: Department of Public Health and Welfare, Broadway State Office Building, Jefferson City, Missouri 65101

NAME OF DIRECTORY: "Medical Care for Public Assistance Recipients in Missouri" (Informational Leaflet No. 3)

FEE: No charge

BRIEF DESCRIPTION: This pamphlet outlines what persons are eligible for medical assistance, what medical care is provided, how one goes about receiving needed medical care and payment procedures.

ORGANIZATION: Division of Welfare

ADDRESS: Department of Public Health and Welfare, Broadway State Office Building, Jefferson City, Missouri 65101

NAME OF DIRECTORY: "Public Welfare in Missouri"

FEE: No charge

BRIEF DESCRIPTION: Lists and gives general information about the scope and character of public welfare in the state of Missouri.

ORGANIZATION: Division of Welfare

ADDRESS: Department of Public Health and Welfare, Broadway State Office Building, Jefferson City, Missouri 65101

NAME OF DIRECTORY: "Services for the Blind in Missouri" (Informational Leaflet No. 9)

FEE: No charge

BRIEF DESCRIPTION: Gives information on vocational rehabilitation, home teaching for the blind, prevention of blindness, services to blind children and aid to the blind--blind pensions. Also lists district and area offices of services for the blind.

ORGANIZATION: Missouri Association for Retarded Children

ADDRESS: 230 West Dunklin, Jefferson City, Missouri 65101

NAME OF DIRECTORY: "Missouri Association for Retarded Children Directory"

FEE: No charge

BRIEF DESCRIPTION: This booklet is primariiy a referral directory. It lists the officers, board members and committees of the Missouri Association for Retarded Children, and explains membership and time that meetings are held. The booklet gives information on regional diagnostic clinics and contains a listing of businesses throughout the state of Missouri that employ the handicapped.

ORGANIZATION: Missouri Crippled Children's Services

ADDRESS: 705 S. Fifth, 3rd Floor, Clark Hall, Columbia, Missouri 65201

NAME OF DIRECTORY: "Missouri Crippled Children's Services"

FEE: No charge

BRIEF DESCRIPTION: Lists the various services that are available to crippled children in the state of Missouri and how to go about contacting those services desired.

ORGANIZATION: Missouri Speech and Hearing Association

ADDRESS: Miss Mary Trombetta, Speech and Hearing Department, Southeast Missouri State University, Cape Girardeau, Missouri 63701

NAME OF DIRECTORY: "Missouri Speech and Hearing Association Members"

FEE: No charge

BRIEF DESCRIPTION: Lists all members of Missouri Speech and Hearing Association, marking all those who are also members of the American Speech and Hearing Association. In most cases, membership in the American Speech and Hearing Association implies a Master's Degree level of training.

ORGANIZATION: State Department of Education

ADDRESS: Arthur L. Mallory, Commissioner, Jefferson City, Missouri 65101

NAME OF DIRECTORY: "Resource Directory"

FEE: Available without charge on microfiche. Printed copies no longer available but have been distributed to public schools.

BRIEF DESCRIPTION: Provides a directory of statewide and community referral sources which can be used to identify a number of organizations which provide various services. Examples of resources included are: Regional Diagnostic Clinics, various Catholic youth and family services, hospitals and clinics having special education departments, mental health centers, Missouri Crippled Children's Service, Bureau for the Blind, Central Institute for the Deaf, University of Missouri's Speech and Hearing Clinic and Child Study Clinic, etc.

This directory will be updated and available from the University of Missouri Extension Division by June, 1974. Publications can be ordered from: Publications, 205 Whitten Hall, University of Missouri-Columbia, Columbia, Missouri 65201.

C. Local Directories and Services

ORGANIZATION: County Health Departments

School districts within counties having a County Health Department should contact the Director for information on available public health services.

Districts within an unorganized county (one in which there is no organization within county lines for public health activities) should contact one of the following Missouri Division of Health District Offices:

District 1	Arnold Reeve, M.D. Cameron
District 2	Lyle O. Partin, D.O. Macon
District 3	E. E. VanVrankin, M.D. Jefferson City
District 4	S. B. Beecher, M.D. Poplar Bluff
District 5	O. A. Griffin, M.D. Springfield

ORGANIZATION: University of Missouri Extension Service

Every area in Missouri is served by an Extension Child and Family Development Specialist who is available for consultation on organizing preschool groups, parent education, preschool teacher training, and general information on children and families. These specialists also have available many Extension publications dealing with child related topics.

Consult your local telephone directory for your nearest University of Missouri Extension Center or contact: Extension Child and Family Development Department, 35 Stanley Hall, University of Missouri, Columbia, Missouri 65201

ORGANIZATION: Regional Health and Welfare Council of Greater Kansas City

ADDRESS: Information and Referral Service, Union Station, Kansas City, Missouri 64108

NAME OF DIRECTORY: "Where to Turn"

FEE: $5.00

BRIEF DESCRIPTION: Gives information regarding services, fees, referral procedures and other general information on almost all public and private agencies in the Greater Kansas City area.

ORGANIZATION: Kansas City Mental Health Association

ADDRESS: 417 East 13th Street, Kansas City, Missouri 64106

NAME OF DIRECTORY: "Mental Health Resources in Greater Kansas City"

FEE: No charge

BRIEF DESCRIPTION: An Index lists the agencies in Greater Kansas City by the types of services they offer. The major portion of the Directory summarized what each agency can do for people with emotional problems.

ORGANIZATION: Regional Health and Welfare Council of Greater Kansas City

ADDRESS: Route 17, Kansas City, Missouri 64139

NAME OF DIRECTORY: "Where to Turn in Southeastern Jackson County"

FEE: No charge

BRIEF DESCRIPTION: Similar to the directory, "Where to Turn", although restricted to services available in southeastern Jackson County and a few major ones in Metropolitan Kansas City.

ORGANIZATION: Health and Welfare Council of Metropolitan St. Louis

ADDRESS: 915 Olive Street, St. Louis, Missouri 63101

NAME OF DIRECTORY: "The Community Service Directory"

FEE: $6.75 including postage (1972 edition)

BRIEF DESCRIPTION: Lists and briefly describes 508 voluntarily financed and tax supported, not-for-profit agencies, institutions and organizations serving the St. Louis area in the fields of social welfare, health, recreation and, to a lesser degree, education. (St. Louis Metropolitan area is comprised of St. Louis City and County, and Franklin, Jefferson and St. Charles Counties.)

ORGANIZATION: St. Louis Council for Children with Learning Disabilities

ADDRESS: 111 South Bemiston, St. Louis, Missouri 63105

NAME OF DIRECTORY: "1973 Directory of the St. Louis Council of Missouri Association for Children with Learning Disabilities"

FEE: $1.00

BRIEF DESCRIPTION: Listings of services in the greater St. Louis area for evaluations and remediations of children with learning disabilities and/or emotional disorders.

ORGANIZATION: St. Louis AEYC and Child Day Care Association of St. Louis

ADDRESS: 915 Olive Street, St. Louis, Missouri 63101

NAME OF DIRECTORY: "Nursery Schools and Day Care Centers in Metropolitan St. Louis"

FEE: $.50 plus postage

BRIEF DESCRIPTION: Lists names, addresses and phone numbers of day care centers and nursery schools in Metropolitan St. Louis. Gives information on the type of center, the ages served, and is coded according to whether the center is for handicapped and/or retarded children. The directory is organized by sections of the city and county geographical areas.

Appendix A, Part 3

FOLLOW-UP LEARNING ACTIVITIES

I. Gross Motor Development

As the child grows in awareness of his body and how it works, he improves his skills of moving about and interacting in his environment. The following activities can be used to facilitate gross (large) motor development.

A. Body Awareness

1. The child must have a mental image of his own body before he can relate himself to the space around him. His natural fascination for looking at himself in a mirror can help him learn how his body is put together and how various parts function.

2. Ask the child to point to his head, eyes, ear, nose, chin, shoulders, thumbs, elbows, ankles, waist, etc.

3. Ask him to move various parts of his body on command: bend knee, raise arm, clap hands, wiggle thumbs, raise eyebrows, etc.

4. Teach the meaning of different body positions: sitting, standing, kneeling, lying down.

B. Balance

1. Have the child stand on one foot for 10 seconds, then on the other.

2. Use a line on the floor for walking forward then backward, heel to toe.

3. Using a low balance and board four inches wide practice walking forward with arms extended out from shoulders.

4. Walk sideways and backwards.

C. Locomotion Skills

1. Crawl on hands and knees moving forward, backward, and sideways.

2. Roll on the floor like a broomstick, like a ball.

3. Walk: like a soldier; on tiptoes; by crossing feet; in a circle, square, and triangle; up and down stairs, using alternate feet.

4. Jump with both feet: forward, backward, sideways, over low obstacles, jump rope.

5. Hop on one foot: forward, backward, sideways, changing feet.

6. Slide, moving the feet as if ice skating.

7. Run by landing on the balls of the feet with heels slightly off the floor: slow, fast, in a straight line, in a circle.

8. Follow footprints: step or hop on path of footprints made from construction paper, red for right foot, green for left.

9. Gallop, as if riding a broomstick.

10. Skip, as step-hop.

D. Animal Actions

Show your child how he can learn to move his body in different ways by imitating animals:

1. Cat Stretch---From an "all-fours" position, stretch one leg back with the knee straight, and, at the same time, stretch neck back as far as it will go. Then bring the leg back, and stretch out the other leg.

2. Elephant Walk---Tell your child to pretend he is as big and heavy as an elephant. Have him bend forward, arms down with hands clasped to form a trunk. Have him imitate the slow lumbering walk of an elephant, swinging his trunk from side to side.

3. Frog Jump---From a frog position, knees bent into a squat, and arms straight in front...jump forward, raising arms and hands high into the air, then returning to the squat position. Continue jumping forward, raising the arms high into the air.

4. Spider Crawl---Have your child sit on the floor with his hands placed on the floor in back of his hips, knees bent with feet flat on the floor. Then have him raise his hips up high, making a "bridge", and walk backwards on his hands and feet.

5. Seal Walk---This movement develops the arm and shoulder muscles, because the full weight of the body is pulled forward from this position: elbows and forearms are flat on the floor, the legs dragging behind.

6. Inchworm Creep---Place both hands and feet on the floor with body raised. Walk with feet until they reach the hands on the floor. Then walk forward on the hands, keeping the feet still. This continues: moving or walking feet to hands, then walking hands away from feet.

E. Bean Bag and Ball Activities

1. Roll a ball from a sitting, kneeling, standing position.

2. Throw bean bags, ballooms, balls: overhand, underhand, at a target four feet away, then increasing distance.

3. Play catch with bean bags, balloons, large balls, slightly underinflated.

4. Kick balloons and large balls at a target.

5. Bounce and catch a large ball, beginning with 13" diameter.

Adapted from: Materials prepared for use by teachers and parents of preschool and kindergarten children, Ferguson-Florissant School District.

II. Fine Motor Coordination

Small hands need lots of practice in strengthening the muscles that are used in drawing, writing and cutting and in coordinating hand and eye. The following activities facilitate the development of fine motor skills.

A. Hand and Finger Exercises

1. Squeeze a small rubber ball, crumpled paper ball, or sponge in time to music or a rhythmic beat.

2. Use one hand, without touching the body or other hand, to wad a sheet of paper into a ball.

3. Playdough, clay, and plast'cene are ideal for rolling, pounding, squeezing, and shaping into all sorts of creative forms.

4. A paper punch, used over a waste can or box, provides good hand exercise along with fun.

5. Pick Up Sticks is an excellent game for developing good finger dexterity.

6. Place hands flat on table, palm down. Tap the table with the thumbs ten times. Repeat for each finger, one at a time.

7. Practice touching thumb to each finger of that hand going from forefinger to little finger and back. Repeat, using both hands at the same time.

8. Pick up buttons and other small objects one at a time and hold them in the same hand used to pick them up.

9. Finger plays and action songs help to develop finger dexterity.

B. Hand-Eye Coordination

1. Hammer and nails are excellent tools for developing hand-eye coordination. Once the child has become proficient at driving nails into soft wood have him follow a line or dots drawn on the wood.

2. "Pour" a ball from one plastic cup to another. Graduate to dry cereal, sand or rice, then liquids.

3. String any number of objects according to a pattern: spools of colored thread, painted spools, assorted buttons, wooden beads. Begin with very simple patterns, such as one red, two blue, or one large, one middle-size, one small.

4. Provide an assortment of jars and jar lids and nuts and bolts of various sizes for the child to screw and unscrew.

5. Working puzzles of increasing difficulty develops coordination of hand and eye.

6. Teach the correct way of holding a crayon and paint brush between the thumb and second finger, with the first finger resting on top. Tracing around large templates, drawing a line between two lines, tracking a dotted line helps children to develop control of the crayon and to give form to their drawings.

7. Small pans of rice or sand are ideal for children to practice drawing shapes and writing letters and numerals using their forefinger for writing or drawing.

8. To teach children to use a scissors with control use a spring-type clothespin to get the feel of the cutting action. Inexpensive "lefty" scissors are available for left handed children. Newspaper is ideal for learning how to cut fringe and to cut on a line. Use six inch square scraps for learning how to round corners and cut in a circular pattern. In cutting, as in reading, a child should hold the paper about 12 inches from his eyes.

Adapted from: Materials developed by the Ferguson-Florissant School District and the St. Louis County Health Department, Division of Mental Health.

III. Speech and Language Stimulation

The following are suggestions for things you can do with your child at home which will help him learn to use language. The most important thing is to make talking a pleasant experience. If you keep in mind the idea that talking is fun, the activities you use will be enjoyable for both of you. If you give your child the idea that what you are doing is going to be hard and thus will require lots of work, or that he must do it, you will probably have less success with your attempts. Use your imagination and try to make a game out of these activities.

First of all, talk to your child, in simple sentences, about everything you do. For example, it is better for you to say, "I'm making cookies", than it is to say, "I think I'll go into the kitchen and make some chocolate yum-yums". When in the kitchen, talk about what you are doing; if you're baking cookies, name the spoon, bowl, flour, eggs, milk, etc. Let him help you, too. When you're eating, name the foods, dishes, and silverware that are on the table. If you have other children, they too, can participate in this naming activity by saying, "Please pass the _____", or, "This _____ is good", etc. Encourage everyone to ask the child to pass things he can handle, like the salt and pepper. Show him objects in your home and outdoors. You can talk about the furniture while you're cleaning house, and again, let him help you. When you're outdoors you can talk about the grass, trees, flowers, rocks, and so on. You can let your child pick up twigs, rocks, flowers, and leaves, bring them home, and then the two of you can tell the rest of the family what you have found. Bathtime and bedtime are good opportunities to name his body parts and clothes. During the bath you can play, "let's wash your (eyes, nose, hair, arm, etc.)", and you can play "peek-a-boo" while you dress him.

Remember that gesture accompanied by speech will aid in your child's understanding of what you say. Do not demand that he repeat what you say, but do reward him for his attempts at speech. A good way to do this is to give him the object which he has indicated he wants, and repeat the correct name as you give it to him. For example, if he says, "wa", for a drink of water, you can give him a drink, saying, "water". If he holds out his hands and grunts when he wants you to pick him up, you can say, "up-up-up" as you're picking him up. Or, when the child indicates he hear something by pointing to it and verbalizing, such as a train or airplane, you can say, "airplane" or "train". This way he is rewarded for talking and at the same time he gets a good model of the words he's trying to say.

Since children learn the speech patterns they hear everyday, it is important that you provide him with a good model. Listen to yourself. Do you use clear, easily understood speech? Do you talk loudly enough for your child to hear you? Do you use long, complex sentences when you can use short, simple ones? It is important that you are using your best speech so your child will have a good pattern to follow.

As we have mentioned before, the child who does not have to talk probably will not be motivated to do so. If your child cannot or does not talk at all, you can reward his gestures by giving him what he wants and naming the object as you do so. If he points to the cookie jar, go ahead and give him the cookie, but name it as you do so. In this way you are still rewarding him for his attempts at communication, even though he does not speak. However, if, for example, you know your child wants a cookie and he can say an approximation of the word, wait for him to ask before giving it to him. In this way you reward his attempt at speech and at the same time give him a model by saying the word, "cookie".

In addition to parents sometimes anticipating a child's needs, his brothers and sisters often will tend to talk for him. This should be discouraged as much as possible. An alternative would be to ask the brother or sister to look at picture books and/or play naming games with the child. The two children can look at a picture book and the older child can read the story or name the pictures. The older child should be discouraged from criticizing the younger child's speech. Children can sometimes be good teachers.

It is important that you, in fact your whole family, become good listeners. When a child does begin to talk, he should not have to fight to get your attention and he should not feel that what he is saying is not important to you. Try to make a special effort to "tune in" while your child is talking and respond to him. Look at him and stop what you're doing if possible. You can ask him questions and make comments about what he's telling you. If he's telling you about going to the store with mother and seeing a man with some balloons, you can comment, "You went to the store. What color were the balloons?", etc.

You can also teach your child to be a good listener. It is easy to make a game out of listening to sounds around your home. These include sounds that animals make, doorbell, sweeper, pots and pans rattling in the kitchen, and other bells and whistles. When you're outdoors you can listen for birds, airplanes, trains, etc. You can identify the sounds you hear each day and and "keep score" as to the number of times your child indicates he hears them.

Reading to your child is important. Children can nearly always benefit from this kind of activity if you proceed in the right way. At first "reading" simply means looking at the pictures in books, magazines, and catalogues that the child likes. The best way to do this is to name the pictures of the things the child sees. Simply point out familiar objects and name them: "the boy, the puppy, the table", etc. After you have named the pictures and are sure the child knows what they are, then ask him to point to the pictures you name. Don't ask him to do any naming, but do reward him if he tries. When he can successfully point to the pictures you name, then ask him to name the pictures you point to. Thus, if you point to a picture of a dog and he says "goggie", you can say, "That's right, doggie". A child gets relatively little out of leafing through a magazine or book by himself; he really needs the guidance of an adult or an older child.

Another game to play is that of repeating sounds. If you have some toy farm animals, both of you can play with them. Name the animal (cow), produce the sound it makes (moo), and encourage the child to join in, rewarding

him for his attempts. The same thing can be done with toy cars and trains. You both can move the train around the room, saying, "ch-ch-ch-ch", as it moves. Sounds can be invented to go with other toys.

In summary, these are the things we have suggested:

1. Make talking a pleasant experience.
2. Talk to your child in simple sentences.
3. Talk about everything you do, again, using simple sentences.
4. Use gesture while talking to your child.
5. Reward him for speech attempts.
6. Provide him with a good model.
7. Be consistent in your discipline.
8. Don't withhold your love because of your child's poor speech.
9. Don't anticipate his needs.
10. Don't let brothers and sisters talk for him.
11. Be a good listener.
12. Read to your child and name pictures.
13. Make a game out of listening to and saying sounds.

Remember that your child is a person and treat him as such. Respect his wishes and if he is tired or disinterested in what you're trying to do, don't push him; try again at a better time for him.

It is important for you to understand that it may take a long time for you to see the effects of what you are doing. Don't get discouraged or give up if you don't see immediate improvement. As has been mentioned before, the task of learning to talk is not an easy one. If you can be consistent in your relationship with your child, expect enough, but not too much, and give him the idea that talking is fun, you will make his task of learning language easier.

More Specific Activities

1. Try to teach a new word a day. Encourage the use of this word in sentences and conversations.

2. Encourage your child to use additional descriptive words in relation to concrete objects. (There is a big, red balloon.)

3. Make a scap book for your child. Allow him to cut pictures out of magazines and catalogues and paste them in the scapbook. He should be encouraged to name and describe the pricures.

4. If a record player is available, have your child listen to records of animal sounds, sounds of the city, etc. and identify them. He could possibly find pictures of them and paste them in the scrapbook.

Adapted from: A Home Program in Language Stimulation, Beverly Ramsel and Sandra Edson, University of Kansas Medical Center

IV. Personal and Social Development

A child needs freedom to grow, to learn on his own, to become independent. As he explores the world around him, he becomes aware that there are limits to what he can and cannot do. He also comes to understand to some degree why limits are necessary. With encouragement and direction, children can accept the standards parents have for them and gradually take over these standards as their own. This is how children learn to decide for themselves what is right or wrong, and eventually to develop self-control. Discipline becomes self-dicipline.

As children interact with their peers, older children and adults they learn what others expect of them and what they can consistently expect in return. With this knowledge comes self-confidence and a feeling of security.

In fostering the child's personal/social development some worthy goals to be considered are:

1. Self-confidence; a child needs to feel good about himself.
2. He needs to view himself realistically, recognizing both his strengths and weaknesses.
3. He needs to respond favorably to others and to gain social acceptance.
4. He needs to develop an honest sense of right and wrong.
5. He needs to accept responsibility for his own behavior rather than blaming it on others.
6. He needs to accept the reasonable exercise of authority, learning to follow laws, rules, etc.

Teach the child to be independent in caring for his personal needs:

1. Toileting
2. Washing hands, bathing
3. Dressing himself
4. Eating
5. Picking up toys, etc.
6. Asking for what he wants or needs

Allow sufficient time for the child to do these things for himself. Provide shelves, furniture, towel racks, etc. that are child-size so that children can learn to care for themselves and for their possessions. Think about ease in dressing when buying clothing so that it is big enough and simple to manage.

Provide many opportunities for socialization, to:

1. Play with friends.
2. Participate in small groups, attend parties, etc.
3. Visit places of interest such as the zoo, post office, grocery store, airport, etc.
4. Share with others, take turns.
5. Listen carefully and follow directions.

Always be fair, firm and honest in dealing with the child's behavior:

1. Above all be consistent. Don't laugh at his behavior in one situation and yell at him for the same behavior in another situation.

2. Give clear directions--allow sufficient time (making certain the child understands what is expected) and then act. If the task is completed, a favorable response is likely to reinforce it for the future. If the task is not completed satisfactorily, firm but constructive assistance is expected and necessary.

3. Convey the idea that a child must do something not because you say so, but because it is a rule. When at all possible enlist the child's help in setting the rules.

4. When you become angry emphasize that while you don't like his behavior, you still like him.

5. Have more Do's and fewer Don'ts. It's easier on everyone concerned if the rules are as few as possible, and are firmly, consistently, and fairly enforced. The child must be capable of achieving these expectations successfully.

6. In most instances it is best to deal with problems when they arise, rather than "waiting until Daddy gets home." By and large children respond better to quiet firmness than to shouting.

7. Spanking is not likely to ruin a child's life providing he is confident that his parents care for him, and are on his side. But there are many kinds of spankings given in very different moods. Spanking out of anger or spanking that deliberately sets out to humiliate a boy or girl is perhaps the most harmful.

Regarding punishment:

1. When it seems necessary, punishment should be brief.
2. Punishment should not be evaded or unnecessarily postponed.
3. See that your child understands why he is being punished.
4. It's the way in which parents punish, more than what they do, that sets the tone.
5. Gear whatever you do to your particular child and the situation.
6. One must expect that children may fuss and bluster when they are corrected. Prepare for it with understanding.
7. Parents can pretty well judge the quality and effectiveness of their dicipline and guidance by the way in which children carry on their daily lives.

Do not consider crying or a temper tantrum to be an earth shaking event. Let your child know that the world will not stop or give in to his selfish whims and that you will consistently intervene when his behavior jeopardizes his welfare or the welfare of others, including your own.

Mutual respect means that you respect children as they respect you. Praise children for the things they do right, just as you recognize and help them to recognize where and how they can do better. Respect their property and their need for privacy as you would expect them to respect yours.

Adapted from: DENVER DEVELOPMENTAL SCREENING TEST: A HANDBOOK, Southeastern Jackson County Mental Health Association

APPENDIX B

SCREENING INSTRUMENTS AND PROCEDURES

The following survey of available instruments is not intended to be limiting or prescriptive but rather to provide guidelines for selecting measures appropriate for early screening. A balanced assessment of several areas of development may be obtained through use of a single reasonably well-rounded screening instrument or through a combination of more narrowly designed tests. Suggested areas of assessment include: personal-social development, language development, gross motor skills, fine motor skills, visual acuity, and hearing sensitivity.

Availability of personnel to administer the instruments as well as the preferences of those responsible for interpreting the findings will affect the selection of measures to be used. Face sheet data should include the following: child's name, mailing address, birthdate, chronological age, birth certificate number, name of parent or guardian.

I. The following instruments provide for screening in several areas of development.

A. Denver Developmental Screening Test, 1970

The DDST is made up of 105 items, evaluating accomplishments of children from birth to six years. The test measures development in four areas:

Personal-Social--The child's ability to get along with people and to take care of himself.

Fine Motor-Adaptive--Ability to see and use his hands to pick up objects and to draw.

Language--Ability to hear, carry out commands, and to speak.

Gross Motor--Ability to sit, walk, and jump.

A delay in development is indicated by failure to pass an item which 90% of children of the same age can perform.

Test items appear to have greater strength at ages three and four than at ages five and six.

Time required to administer the test is approximately 25 minutes. Some items require response by parent or caregiver.

Publisher: Ladoca Project and Publishing Foundation Inc.
51st Avenue and Lincoln
Denver, Colorado 80216

B. DABERON. 1972

This is a screening tool for children ages four to six. It is designed to sample knowledge and skills of children as a means of predicting readiness for school activities. It surveys:

Knowledge of body parts	General knowledge
Color and number concepts	Visual perception
Functional use of prepositions and plurals	Gross motor development
Ability to follow directions	Ability to categorize

Developmental age levels are indicated for most of the 124 items on the test, ranging from eighteen months to six years.

This test is especially strong in language assessment. It appears to be a more useful instrument at ages four and five than at age six. While the test lacks research and predictive estimates, the skills assessed should provide useful information for program planning. Test items have been chosen from those well researched in the literature and in other tests such as the Denver and WIPSI.

The DABERON can be individually administered in about 20 minutes.

Publisher: DABERON Research
4202 S.W. 44th Avenue
Portland, Oregon 97221

C. Dallas Preschool Screening Test, 1972

This screening test is designed for children ages three to six. It evaluates skill development in these areas:

Psychological--Name, age, counting, noun association.

Auditory--Digit memory span, word memory span.

Visual--Color naming, matching, reproducing forms.

Language--Body parts, picture description.

Motor--Size relationships, writing name, gross motor.

Developmental age levels are given for each test item, ranging from three to six years. The test takes about 15 minutes.

Publisher: Dallas Educational Diagnostic and Development Center
725 South Central Expressway, Suite A-15
Richardson, Texas 75080

D. Screening Test of Academic Readiness, 1966

The STAR is primarily a test of school readiness with an age range of four to five years. It is a 50-item paper and pencil test with only one item appearing on each page of a multi-colored booklet. This format lends itself to group testing with five year olds; however, individual administration is preferable at age four.

Areas tested include:

Picture vocabulary
Letter identification
Printing name
Identifying missing parts
Reproducing forms
Human figure drawing
Picture description (concepts)
Relationships
Numbers

An average range is given for each subtest according to chronological age.

The STAR can be administered as a group test in two 20-minute sessions.

Publisher: Priority Innovations, Inc.
P. O. Box 792
Skokie, Illinois 60076

* * *

II. Because of limitations in the number of areas tested or in the number of items provided at each age level the following instruments may best be used as supplementary to or in combination with other measures.

A. Preschool Attainment Record (PAR), 1966

The PAR is an informant type developmental scale used to evaluate children between the ages of six months to seven years. The scale measures development in three areas:

Physical--Measuring manipulation and ambulation abilities of the child.

Social--Measuring development in responsibility, communication, and rapport.

Intellectual--Measuring the information, ideation, and creativity demonstrated by the child.

The PAR is administered through an interview with an informant throughly familiar with the child. As such, it does not evaluate a child's ability

to perform a task at a particular time; but rather measures his habitual behavior.

The current PAR is a research edition and is not yet normatively standardized.

The test requires about 20 minutes to administer.

Publisher: American Guidance Services, Inc.
Publishers Building
Circle Pines, Minnesota 55014

B. Caldwell Cooperative Preschool Inventory, 1970

The Caldwell is a screening tool designed for individual use with children in the age range of three to six years. The test seems strongest in the four to five and one-half age range. It is designed to measure achievement in areas regarded as necessary for success in school. It evaluates:

Visual perception--Pointing to geometric figures

Motor skills--Copying geometric figures and coloring

Body imagery--Identifying body parts

Conceptualization--Number concepts and abstract reasoning

School readiness

The Caldwell is a highly verbal test and as such indirectly evaluates receptive and expressive language skills. It is also culturally biased, as stated in the manual, and evaluates the degree of disadvantage displayed by the child.

Publisher: Educational Testing Service
Princeton, New Jersey

C. Early Detection Inventory, McGahan, 1967

This instrument assesses readiness in four specific areas:

Social-Emotional Behavior--Responses observed by the examiner during testing

School Readiness Tasks--Concept development, awareness of body image, left and right, verbal self-awareness

Motor Performance--Gross and fine motor, hand and eye preference

Personal History--Family and social history, medical history

Optimal age application seems to be four to five years. Although the test items are diversified they are somewhat limited in number in each subtest area.

The Family and Social History may require a skilled professional for proper interpretation of this section of the test.

Publisher: N.E.P. Education Service Center, Inc.
3065 Clark Lane
Paris, Texas 75460

D. Riley Preschool Developmental Screening Inventory, 1969

Age range for the Riley is three to five years. This measure of school readiness can be administered individually, in small groups, or with a total class. It evaluates ability to draw a person and reproduce geometric forms. Suggested cut-off scores for referral are given.

Publisher: Western Psychological Services
Box 775
Beverly Hills, California 90213

E. Meacham Verbal Language Development Scale, 1958

The Meacham is an extension of the communication portion of the Vineland Social Maturity Scale by Edgar Doll. It is administered by the informant-interview method. The test is designed to be used with children between the ages of four months to fifteen years. It appears to have its strengths at the one and two year levels evaluating nine items at each level. At other age levels the child is evaluated through four items.

The Meacham was standardized on a sample of 120 normal speaking children which included five boys and five girls on each of the twelve age levels on the scale. The number of items evaluating each age group is limited; thus it offers only a cursory view of language.

Publisher: American Guidance Service, Inc.
Publishers Building
Circle Pines, Minnesota

F. Tests of Basic Experiences, Level K, 1970

The Tests of Basic Experiences (TOBE) are a series of group tests for young children. Level K is designed primarily for five year olds. The tests are designed to measure the child's familiarity and facility with educationally relevant concepts in the areas of mathematics, language, social studies, and science. There are separate test booklets for each subject area and a fifth one which samples all areas.

Publisher: California Test Bureau
McGraw Hill
Del Monte Research Park
Monterey, California 93940

G. Preschool Language Scale, 1969

The Preschool Language Scale is a comprehensive language test and appears to be a useful diagnostic tool. This test evaluates the receptive and expressive aspects of language in children between the ages of eighteen months to seven years. The purpose of the auditory comprehension scale (receptive) is to determine whether a child can receive auditory information and can indicate this reception by a meaningful, non-verbal response. The verbal ability section (expressive) evaluates the child's oral language skills providing for measurements of:

Vocabulary	Concept acquisition
Verbal memory span	Articulation
Concrete and abstract thought	Grammatical structure

Publisher: Charles E. Merrill Publishing Company
Columbus, Ohio

* * *

III. The following instruments would be appropriate as behavior checklists to be used in conjunction with other screening devices:

A. California Preschool Social Competency Scale, 1969

This scale consists of 30 items which are representative samples of what might be considered critical behavior in the preschool child's social functioning. The norms are based on teacher ratings of children from two years and six months through five years and six months who are attending preschool or nursery school programs.

Consideration could be given to inclusion of this test as a parent rating form to be completed during the time the child is being tested. It could also be used by teachers after a period of observing and working with children.

Publisher: Consulting Psychologists Press, Inc.
577 College Avenue
Palo Alto, California 94306

B. Vineland Social Maturity Scale, 1965

This scale is designed to measure social competence from birth to maturity. Parent participation is required. Areas evaluated are:

Self-help	Communication
Self-direction	Locomotion
Occupation	Socialization

There are a limited number of items, however, in each age range above age three. The total score is expressed as "social age."

Publisher: American Guidance Service, Inc.
Publishers Building
Circle Pines, Minnesota 55014

C. Symptom Checklist, 1970

The following symptom list was adapted for use with children ages four and five by the Parent-Child Early Education Program in the Ferguson-Florissant School District. It asks parents to report the presence or absence of "problems" in each symptom area, as part of a larger checklist on which parents are asked to evaluate other aspects of their child's development as well. The items were adapted from the Glidewell Inventory, used in research by the Mental Health Division of the St. Louis County Health Department. It is suggested that in using this information in identifying emotional problems in children a clinical psychologist, child psychiatrist, or psychiatric social worker be consulted for purposes of final judgments.

During the past 12 months, MY CHILD has had trouble with: Check one:	Often	Once in awhile	Not at all
Eating (too much or too little)			
Sleeping (too much or too little)			
Stomach irregularities			
Getting along with children			
Getting along with adults			
Unusual fears			
Nervousness			
Thumbsucking			
Overactivity			
Sex			
Daydreaming			
Temper tantrums			
Crying			
Lying			
Stealing			
Tearing or breaking things			
Wetting			
Speech			

Reference: A fairly recent compilation of available instruments, Tests and Measurements in Child Development: A Handbook, by Orval G. Johnson and James W. Bommarito, Jossey-Bass, Inc., Publishers, San Francisco, Calif., 1971.

IV. Vision Screening

A. Who should be screened?

All children should be screened, with particular attention to any child who rubs his eyes excessively, holds his head at an angle, squints excessively, or holds objects close to his eyes.

The child who has pupils of different size, drooping eyelids, pupils that appear cloudy, crossed eyes, recurring sties, eyes that are constantly moving or have experienced a change in color of iris should be screened and referred promptly for further diagnostic consultation.

B. Materials to be used and their sources:

Snellen E Symbol Chart - National Society for Prevention of Blindness, Inc.
79 Madison Avenue
New York, New York 10016

Eye Occluder Q-2134 @ $3.25 each - House of Vision Optical Company, Inc.
137 North Wabash
Chicago, Illinois 60602

Spot Light - one for each Snellen Chart.

Reporting Sheets - Either devise an extremely simple one with spaces for child's name, address, birthdate, parents' name, school district, and visual acuity, or use the visual screening report sheet used by the local school system.

Film - "Before We Are Six"
A film to prepare professionals and volunteers to screen the vision of preschool children. 16 mm. color, sound, 22 minutes. National Society for Prevention of Blindness, Inc., 79 Madison Avenue, New York, New York 10016. Available on loan without charge, except for postage. Purchase price $125. Due to scattered statewide use, it would seem feasible for the State Department of Education to purchase the film.

C. Number of screening personnel needed:

A team of three people is needed for each screening station - one person to greet the child and hold the occluder as each eye is tested separately, a second person to stand at the chart and show the E symbols through a window card, and a third person observes the behavior of the child and records the visual acuity as it is determined.

D. Screening Process:

1. Screening Area:

Placement of E Symbol Chart exactly 20 feet from child being tested.

Level of Chart - mount on an uncluttered, light colored wall at eye level to the child.

Spot Light - directed toward E Symbol Chart.

A chair placed 20 feet from E Chart for the child to sit in when being screened.

A cover card with cutout window in the center. (The window card is held against the Chart to help the child focus on one E symbol at a time.)

2. Visual Testing:

Test right eye first, keeping left eye covered. Record results (see below). Test the left eye, keeping right eye covered. Record results (see below).

If the child wears glasses, test vision both without and with glasses. Record each determined acuity separately; i.e., designate whether the acuity is "without glasses" or "with glasses."

3. Recording Results:

Record visual acuity for each eye, immediately after acuity is determined. The method for determining acuity is as follows:

Right Eye - determine the lowest line on the E Symbol Chart which can be "read" by the child. Lines on the E Symbol Chart are designated 20/200, 20/100, 20/70, 20/50, etc., reading from top to bottom on the chart. The 20/200 line means, in effect, that the child who can read only this line can see at a distance of 20 feet the same items that a person with normal vision (20/20) can see at a distance of 200 feet. Likewise, the child who can read the 20/100 line can see at a distance of 20 feet the same items that a person with normal vision can see at a distance of 100 feet. The same relationship would apply for each succeeding line on the E Symbol Chart. Obviously, the child who can identify those symbols on the lines of the chart which are designated 20/40, 20/30 or 20/20 has better distance acuity than the child who can identify only the symbols on the 20/200 or 20/100 line. Thus, it is extremely important that the acuity for each eye be accurately recorded.

E. Referral for further diagnostic examination

During the years three through five, the child's ability to perceive the shape of objects is still in the developmental stage. For this reason,

the following guidelines for referral are recommended by most eye specialists when the child, age three to five, has the following distance acuity in one or both eyes:

3 year olds: distance acuity of 20/50 or less (missing the 20/40 line on the E Symbol Chart).

4 & 5 year olds: distance acuity of 20/40 or less (missing the 20/30 line on the E Symbol Chart).

The child with a different distance acuity in each eye should also be referred even if results are within the passing standard (a 3 year old with 20/20 in right eye and 20/40 in left).

If the child is already receiving regular eye care, referral is not necessary. Information should be obtained from the eye doctor regarding the eye condition.

1. To Whom Referred:

Eye specialist--an ophthalmologist or physician skilled in diseases of the eye.

2. Resources for Meeting Cost of Needed Diagnostic Examinations:

Title XIX--Medicaid--examinations, and treatment for recipients of public assistance

Local Civic Clubs

Prevention of Blindness (Bureau for the Blind)--medical care program for medically indigent persons (as determined by the State Bureau for the Blind). Medical care is restricted solely to diagnosis and treatment of diseases of the eye.

V. Procedural Guidelines For Hearing Screening

A. Overview:

The critical importance of calibration, test environment, and tester skill precludes any effective and reliable means to provide mass qualification and/or quantification of hearing impairment for preschool youngsters as part of a total identification package. In fact, even the best organized screening program for public school youngsters is no more than an identification, i.e. red flag raiser, program. The question to be answered by any screening or identification program is not "how much hearing is there" or "why doesn't this child hear" but instead "HOW DOES THIS CHILD RESPOND TO SOUND IN COMPARISON TO HIS PEERS." If the child in question responds markedly different to the acoustic environment, then a two-fold obligation is presented:

1. Refer the child for a professional otological/audiological examination.

2. Provide follow-up support to see that resultant educational recommendations, if made, are carried out and understood by both the parents and educational personnel involved with the child.

B. The Identification Process with Preschool Youngsters:

1. High-Risk Etiology

a. Pre-Natal

(1) Rubella
(2) Rh. Incompatability
(3) Hepatitis
(4) Medicine and Drugs
(5) Prolonged Labor
(6) Other Complications

b. Familial History of Hearing Loss

c. Post-Natal

(1) Prolonged Unconsciousness
(2) Prolonged Fevers
(3) Head Trauma
(4) Allergic Conditions
(5) Chronic Head Cold and Congestion
(6) Earache With or Without Drainage
(7) Conditions Requiring Prolonged Antibiotic Treatment
(8) Mumps (Can Result in Unilateral Deafness)
(9) Cerebral Palsy, Cleft Palate, or Other Physical Anomalies

NOTE--These factors provide a source of high-risk guidelines and are not all-inclusive. Neither are these factors necessarily causally related to hearing impairment in every instance. However, if the child's history includes any number of these factors, his auditory behavior should be watched closely until which time that it can be determined how that child responds to sound.

2. Identification Environment

a. The room should be reasonably quiet and should contain toys and objects which will draw and occupy the child's attention.

b. Two people should be involved with the child. One whose role is that of playing with the child; and another who, while out of the field of vision of the child, will employ various sound sources.

3. Stimuli

a. It is important not only to be able to note how a child responds, but also to note whether such responses occur with stimuli incorporating various frequencies, i.e. pitch components. Toy noisemakers are excellent for this purpose including toy drums, bells, crickets, whistles, flutes, pop guns (not cap pistols), kazoos, et cetera. Also, it is important to use speech as a stimulus also. It must be remembered that testing with such gross utensils offers no calibration of intensity and inferences must not be made regarding that parameter.

b. It would be recommended that persons involved with this program first practice on normal youngsters in order to familiarize themselves with the sounds of the toys and with the way the children respond.

4. Responses to Stimuli

a. Remembering that no visual clues are to be allowed, there are several characteristic factors involved in a child's response to sound.

(1) Response Latency

Do not repetitively present the stimulus, since a prolonged response latency of several seconds may be present. Such a delayed latency is indicative of concomitant neurological involvement, but is in fact a response to sound.

(2) Searching for the Sound

Binaural hearing provides localization ability. A child with one normal and one non-functioning ear will respond and search for the sound source but will have difficulty finding it.

(3) Cessation or Activation Behavior

Obvious response to sound.

(4) Subtle Eye Movements Following Stimulus Presentation

Appendix C, Part 1

KANSAS CITY OUTREACH MODEL

Southeastern Jackson County Mental Health Association
Little Blue and Lee's Summit Road, Route 17
Kansas City, Missouri 64139

Director: Ray Morgan

Contact Person:

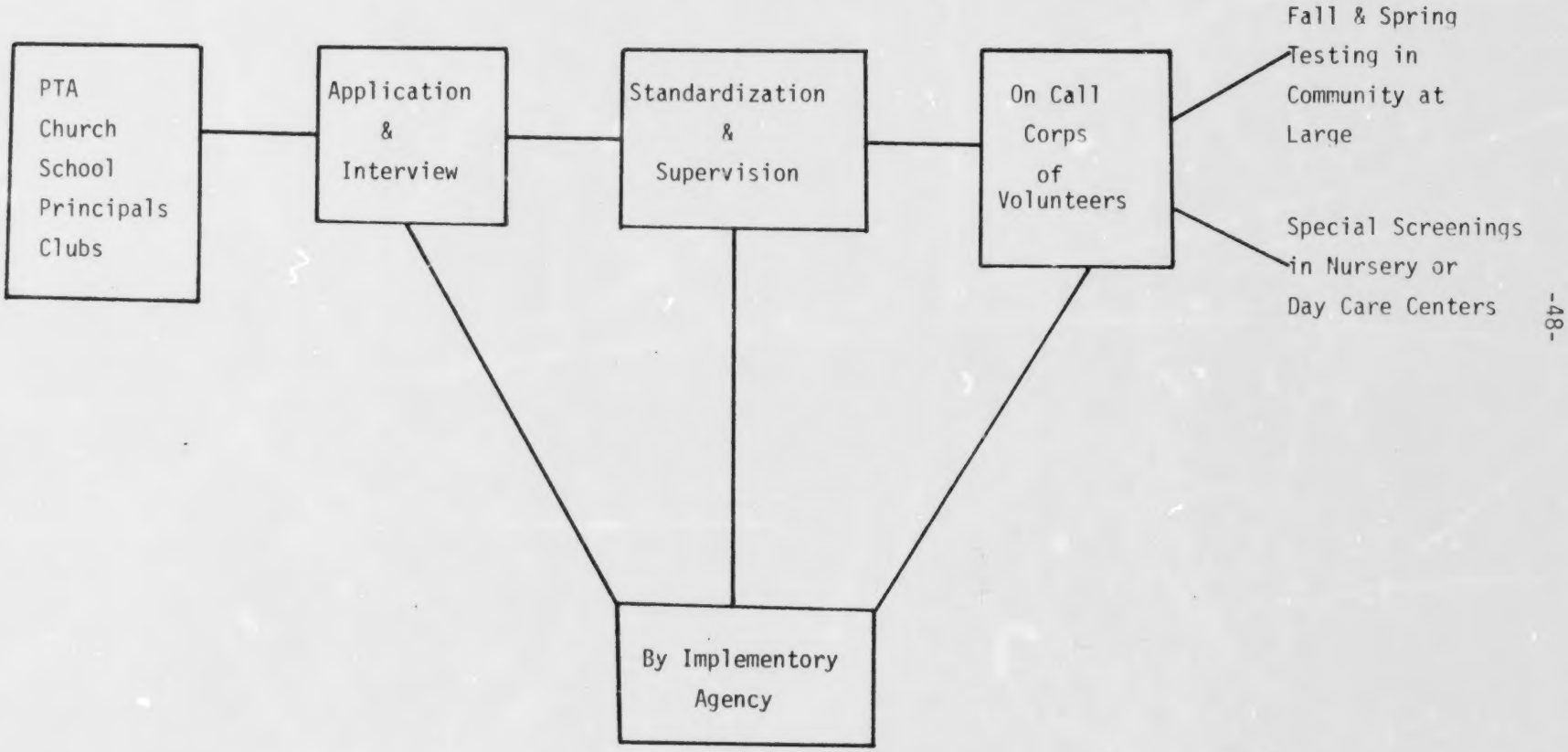
Shirley Fearon, Coordinator
Community Services

816/373-1717

00048

MODEL OF PROGRAM SEQUENCE

Volunteer Resources



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KANSAS CITY OUTREACH MODEL

I. Introduction

Many cases of slow development are not discovered until children enter school. Since it is known that many cases of slow development can be treated if diagnosed early, it is important to identify children with problems in development as early as possible. The Denver Developmental Screening Test, (DDST), developed in 1967 by Frankenberg and Dodds, is a simple useful tool designed to be used by people who have not had special training in psychological testing. It has been standardized on a large cross section of the Denver (Colorado) children. The Test can be administered in a relatively short time with a minimum of testing materials.

II. Selection of Volunteers

Meeting the volunteer and making a personal assessment of her abilities to participate in the screening program is important. It is in this face to face meeting that the implementor can emphasize the need for confidentiality and the desire for good rapport with parents. If there are any blatant reasons for not using the volunteer for screening of children this point of entry is a good place to put the volunteer into another assignment.

Two of the main considerations in selecting volunteers for DDST is his or her ability to get along with children and a genuine liking for children. This can be a "fun" experience for both tester and child. Age or sex is no factor in volunteer selection although the tester should be mature enough to not feel threatened by a balky child. Testers should realize that within the limits of the test each child should be given every opportunity to succeed but this can be overdone, thus invalidating the test.

For sample volunteer application form see page 52.

III. Training Procedures

Training of volunteers should be done by a qualified person. Orientation to program and rationale takes one hour. The mechanics of the tool session will last about two hours, more or less, depending on the number of volunteers. To be most effective the training class should not consist of any more than 20 volunteers. Using the manual as a guide, a test sheet is scored en masse, under the guidance of the instructor. Emphasis is given to the realtionship between the tasks performed and growth and development. In order to be standardized, each trained tester observes at least three times while the test is given by a standardized tester and her scores are compared with those of the tester. She then administers three tests while being observed and again compares her scores with the observer. Any points of difference must be resolved with the manual or interpreted by a resource person. On the basis of previous experience the tester is then felt to be able to test and make standard decisions on the scoring of the child's performance.

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It is helpful to make available to volunteers a review session from time to time. This gives the volunteer an opportunity to question any part of the test and by so doing reinforces her confidence in her ability to administer a valid test. See page 53 for Volunteer Review Test.

Spot checks are done on volunteers to assure that the tool is being used appropriately. In addition, score sheets are surveyed for problem indicators and critique on scoring.

IV. Training Information

A. The parents should be told that this is a developmental screening to obtain an estimate of child's level of development and that it is not expected the child will be able to perform each of the test items. It is not to be confused with an IQ test. Parents should be instructed not to ask questions of the tester regarding the test. Some questions will be asked of the parent, these should be answered honestly. Someone should be available immediately following the test to answer parents' questions. One parent should accompany the child instead of a neighbor or babysitter whenever possible. Kindergarten aged children can be tested alone.

B. Age line should already be drawn on score sheet, this information should be obtained when appointment is made.

C. All items through which the age line passes should be given. In addition each sector should have at least three items which are passed and three items which are failed. Make certain the child has several passes to the left of any failure.

D. In the event a child refuses to do some of the items, it is permissible for the parent to administer the item, provided she does so in the prescribed manner.

E. If the child passes an item a large "P" is written at the hatch mark, "F" denotes a failure, "R" if tester feels child can do item but refused, "N.O." no opportunity. These are the only markings that should appear on the front of the score sheet.

F. Any observations by the tester should be noted on the back of sheet in the space provided. These should include:

1. Adjustment of child to examiner, cooperation, attention span, self-confidence.

2. Whether or not parent felt that child was reacting typically.

3. Child's physical appearance (example: did the child have a cold, an unusual speech or eye problem).

G. Begin the test in the Personal-Social sector. Next Fine Motor, Language, and last, Gross Motor. By starting with the Personal-Social sector, in which many items are given by report of the mother, the shy child has the necessary time to get accustomed to the tester. A shy child will feel more comfortable

doing the Fine Motor before Language. Some children may be reluctant to do the Gross Motor at the start of the test and other children may enjoy the activities so much that they find it difficult to settle down to do the items in other sectors.

H. A delay is any item failed which is completely to the left of the age line. These are emphasized by coloring the right end of the bar of the delayed item. If the age line touches the right end of the bar, the item is <u>not</u> considered a delay.

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DENVER SCREENING VOLUNTEER APPLICATION

NAME _____ _____
Last First Spouse's First Name

ADDRESS _____
Street, Post Office Box, or Route Number

_____
City State Zip

TELEPHONE _____ _____ BIRTHDATE _____

Previous Volunteer Experience (specify): _____

_____

Previous Working Experience (specify): _____

_____

Education _____

Spouse's Occupation _____

Spouse's Place of Employment _____ Telephone _____

Number of Children and Ages _____

When Would Be Available to do Screening _____

Reason for Volunteering _____

References: (2) _____

_____

For office use only:

Date Interviewed _____

Comments _____

Started Volunteer Service (date) _____

DENVER DEVELOPMENTAL SCREENING TEST - VOLUNTEER REVIEW TEST

A. 1. What are the 4 possible scoring marks and what do the mean?

a.

b.

c.

d.

2. Where do you place the scoring mark on the bar?

3. If the child refuses, to do any of the items, what should you do?

4. How many trials should you give before giving a failure?

5. Where do you note observations and what are three things to be aware of?

a.

b.

c.

6. How do you determine how many items are to be tested?

7. You begin the test with items below the age level and continue upward to the right until_____.

8. There should be_____passes to the left of a failure.

9. What does the letter "R" indicate in the bar?

10. What does a number indicate in the bar?

11. What do you say to the parents prior to the screening?

12. What do you say to them following screening?

B. 1. If a child is not able to button, how would you grade on "Dress with Supervision?"_____; How on "Dress without Supervision?"_____

2. What is the last thing you do on the test?_____

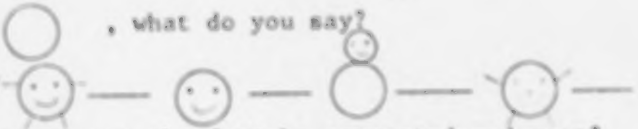
3. What are the rules for passing on "washes and dries hands"?

4. If a child is able to get the raisin from the bottle by removing it with his finger, is it a pass?

5. In picking the larger line, how many can he miss out of 6 and still pass?

6. Can you demonstrate the ?

7. In getting him to draw a , what do you say?

8. How would you grade these? 

9. On the heel & toe walk, how far can the feet be separated and pass?_____

10. If a child balances on one foot for 10 seconds on the 1st try, can you give him a pass?

Appendix C, Part 2

ST. LOUIS COUNTY HEALTH DEPARTMENT MODEL

St. Louis County Department of Health
Mental Health Division
801 South Brentwood Boulevard
Clayton, Missouri 63105

Director: Charles D. Ottensmeyer, M.D.

Contact Person:

Carole Zatlin, Coordinating Psychologist
Early Childhood Screening

Marilyn Dannacher, Social Worker

314/726-1100

ST. LOUIS COUNTY HEALTH DEPARTMENT MODEL

I. Early Childhood Developmental Screening and Counseling Service

This is a service provided by the Mental Health Division of the St. Louis County Health Department through the Child Health Clinics of the Health Department which are held in communities throughout the St. Louis County area. These clinics provide preventive medical care to children beginning at the age of two months.

The instrument used for screening is the Denver Developmental Screening Test which identifies maturational lags in fine motor, gross motor, personal and social growth as well as in language development. The purpose of this service is to locate children who are behind in any of these four spheres and to provide immediate intervention for them through counseling with their parents or referral to the appropriate community resources.

The personnel administering this service consists of a Consulting Clinical Psychologist, a Coordinating Psychologist and Social Worker as well as Psychiatric Social Workers assigned to each clinic and trained volunteers who administer the test. See pages 58 & 59 for outline of training program. This is an effort of the Mental Health Division in it's own unique way to work collaboratively with the medical personnel in these multiple county wide Child Health Clinics consisting of Pediatricians, Pediatric Nurse Practitioners and Public Health Nurses. The program has been positively received by them as it provides these clinics with the opportunity to meet the total needs of the child.

We are focusing our screening on three and four year old children though we are at present including five year olds who are coming for their school physical examinations. Our screening is a part of each child's health examination. The child is tested in the presence of his parent/s to model the kind of tasks a child is expected to master and to give ideas as to the kind of stimulation a young child needs to reach his developmental milestones. Following the administering of the test the results are shared with the parent either by the Psychologist or the Social Worker. Depending on the needs indicated at this time they are counseled in ways in which they as parents can close the gaps in their child's development or they are referred to an appropriate community resource. In our experience we have found children who have shown no lags on the Denver yet whose parents express much concern about their child's behavior.

We are planning to use our existing remediation program as a resource for these children in the near future and also have plans to provide parents groups with an educational focus.

The results of each child's test are recorded in the patient's clinic medical record. The test protocols are kept on file and each Social Worker

keeps a brief record of the test findings, school child will attend, the Social Worker's assessment data as well as recommendations. We are working toward the goal of making the results of our screenings available to each child's school at their time of entry.

We began the service on a limited basis in July of 1972 as a pilot study in one Child Health Clinic. We are now operating in six clinics and when we have staff available we will eventually be providing this service to approximatcly 21 clinics. Many of these clinics meet weekly, others semi-weekly and still others one time a month, dependent on the need of the community.

GUIDELINES PERTAINING TO QUALIFICATIONS AND TRAINING
OF PSYCHOLOGY AIDES FOR EARLY CHILDHOOD
SCREENING ASSESSMENT IN AN ESTABLISHED AGENCY

I. Qualifications of Psychology Aides

A. Selected through in-depth interviewing when possible

B. Written application forms

1. Demographic characteristics: name, address, phone number, present and past occupations and volunteer work, number and age of children, present and future plans and/or ambitions

2. Past experience working or relating to children in 3-5 year age bracket

3. General feeling and attitudes towards young children as well as sensitivity to parental needs and attitudes

4. Expression of confidence in prescribed method and desirability of attaining information of child development for preventative approach

5. Willingness to accept instructions, follow directions, and maintain confidentiality in testing situation

6. Character references from reliable sources

II. Training of Psychology Aides by Professional, Experienced in Child Development and Testing Techniques

A. First hourly training session - (Hand out materials)

1. Preferably not more than four volunteers in session at a time

2. Exposition of work setting, context in which volunteer will be working and expectations regarding his or her role

3. Discuss manual: scope of test, relation of items to child development, limitations of method and testing materials, importance of proper administration and scoring

B. Second training session - (After studying manual)

1. In-depth discussion of administration and scoring of items falling within age ranges under consideration (with administration when possible)

2. Practice giving test to four or five year olds during second week of training

C. Third training session - (After practice)

1. Answer questions, check scoring DDST protocol. Discuss, noting observations of child's behavior and mother-child relationship

2. Role play - each volunteer takes turn giving test and playing child's role

D. Fourth training session - (In clinic or ongoing testing situation)

1. Observe experienced tester

2. Score test protocol along with experienced tester and compare and discuss results.

E. Fifth training session - testing in clinic situation under supervision of experienced tester or by professional

1. Further comparisons and corrections

2. Continued supervision until both tester and observer feel secure

3. Periodic re-evaluation of evaluators

4. Devise procedures for termination of inappropriate volunteers

Appendix C, Part 3

MIRIAM SCHOOL MODEL

Miriam School
524 Bismark
St. Louis, Missouri 63119
Director: Dr. Eleanore Kenney

Contact Person:
Alice Chasnoff, Project Director
314/968-5225

AN EARLY SCREENING PROGRAM WITHIN SCHOOL ENVIRONMENTS

This program was introduced in September, 1972 as a pilot program designed to interest public and private elementary schools, preschools and day care centers in screening for developmental lags. The program is funded by the Education Confederation, a non-profit organization of schools and educational agencies. The following guidelines are suggested ways of implementing the program but can be tailored to the individual school's needs.

I. Rationale:

A. Purpose of Early Screening in Schools

1. Early discovery of delayed development in young children

B. Ways in which the test information can be used

1. Referral of appropriate children for further evaluation of a diagnostic nature

2. Educational planning in the classroom by the teacher for individual children and the group

3. Knowledge of potential "high risk" children

4. A graphic assessment tool for use in parent conferences

II. Initiating Early Screening Program Within a School Environment

A. Initial Contacts

1. Superintendent of School District

2. Director of Nursery School or Day Care Center

These contacts will come either from the above mentioned to the implementing agency or from the implementing agency to the schools.

B. Kinds of school personnel who might be the administrator for the detailed planning and implementation of the program.

1. Assistant Superintendent

2. Curriculum Supervisor

3. School Guidance Counselor

4. School Social Worker

5. Principal

6. Teacher

III. Planning and Implementation

A. Publicity to Parents

1. Description of Program

2. Dates of Screening

3. Enrollment Forms

4. Announcement of Meeting

B. Training of administrator of the program by a professional from the implementing agency. Training in testing and in reporting results.

C. Training of school personnel who will be the testers.

1. Training to be done by a professional who is experienced in administering and reporting results of tests.

2. Persons to be trained

a. Volunteers

b. School Personnel

3. Training Sessions

a. Initial sessions of a minimum of 2½ hours for purposes of discussion of goals, of the test manuals. Demonstration by trainer on how to give the test.

b. A period of ten days which trainee will use to practice giving test to three, four, and five year olds outside of the school environment, i.e. neighbors, friends, relatives.

c. Second session for purposes of item to item examination of tests, discussion, answering questions of trainees.

d. Testing by the trainee under supervision of the trainer including scoring and administration.

D. Implementation

1. Call meeting with parents to discuss rationale, procedures and answer questions

2. Provide adequate time, space and proper equipment for tester and child

3. Provide adequate time and space for parent interviews if they are occuring at the time the test is given

4. All completed tests should be turned in to the school person who is the administrator

E. Reporting Results

1 All completed tests studies by administrator

2. All results of screening reported to parents and all appropriate school personnel and/or outside agencies

3. At the time of reporting results, suggestions for further evaluation, educational planning, other types of referral should be made if, and when, appropriate to the child and family

Appendix C, Part 4

BROOKFIELD SCHOOL DISTRICT MODEL

Brookfield R-III School District
200 Linn Street
Brookfield, Missouri 64628

Contact Person:
Larry Nolte, Elementary Principal
816/258-2241

00065

BROOKFIELD SCHOOL DISTRICT MODEL

The Brookfield R-3 School District serves a town of 5,500 with a large surrounding rural area. The total school population of approximately 1700 students represents a wide range of socio-economic and ability levels.

I. Pre-Kindergarten Clinic

A. Purpose of Clinic

The first pre-kindergarten clinic was organized in the Spring of 1972 and conducted again in the following spring by the same school staff. Knowing that children do not grow and develop at the same rate, the clinic was designed to determine the level of readiness and program needs of each child who would be entering kindergarten the following September.

B. Clinic Staff

The staff for both years included the elementary principal, two kindergarten teachers, elementary counselor, speech therapist, school nurse and kindergarten teacher aide.

C. Parent Contact

In March announcements were put in the local newspaper and on the radio station asking parents of eligible kindergarten students to call the elementary school and give the name, address, and phone number of the child. Other agencies were contacted for assistance such as the Head Start Program and the County Welfare Office. A letter was sent to the parents of each child informing them of the pre-kindergarten clinic--objectives and dates--and inviting them to a parent meeting to be held approximately one week prior to the clinic which was to be held at the kindergarten building. At this meeting the purpose of the clinic and all pertinent information was discussed. The parents were asked to fill out the standard enrollment forms at this time. All staff members were there to answer questions and talk with parents.

Another letter was sent to the parents just prior to the clinic again informing them of the clinic and important information. A bus schedule was included at this time.

D. Screening Measures

1. The broad areas to be evaluated were defined as: cognitive development and skills; motor skills; language and speech development; social-emotional development; attention to task and work habits.

2. Materials were selected or developed to test each of these areas.

a. For evaluation of Gross Motor Development, Marianne Frostig's Movement and Skills Survey from her Move-Grow-Learn Program was used. Only three of the areas from the program were used: Coordination and Rhythm, Agility, and Balance.

b. For the speech evaluation the speech therapist used the Development Articulation Test adapted from Henja, Templin, and Pendergast, and informal conversation elicited through the use of pictures and stories presented.

c. Tests were developed by the counselor for the areas of Basic Experience Skills and Visual-Motor Development. A variety of published references, tests, rating scales, and check lists were reviewed by the counselor for source materials. Great reliance was placed on the works by Gesell et al. The tests used had to meet some restrictive conditions. They had to be brief enough to fit into short time periods. They also had to be administered in small groups; and they had to be constructed so they could be scored objectively or rated in comparison to the performance of the other children.

d. The kindergarten teachers used normal low level curricular activities with the children. They tried to incorporate as many varied activities as possible such as: drawing, coloring, cutting, pasting, musical activities, cooperative games, language activities, stories, etc. Most of the kindergarten teachers' evaluation of the child came through observations of these activities.

e. Prior to the clinic, the staff members were given an Observation Guide compiled by the counselor from Gesell's material and other writing and checklists. The guide summarized some of the more noticeable characteristics of children ages 3 to 6 years of age in the areas of Physical-Motor Development, Intellectual-Language Development, and Personal-Social Development. The guide was used to help the staff to understand and compare some of the more obvious behavior at the different age levels. The guide was also an aid in helping the staff evaluate the Social-Emotional, Work Skills, and Language Development of the children on the rating scale.

3. A Pre-Kindergarten Rating Scale was developed from the above materials, grouping all evaluation items under six main categories. The format of the Rating Scale is as follows:

a. Basic Experience Skills Development
   Name, Address, Age
   Draw a Man
   Counting Objects
   Color Discrimination
   Verbal Concepts

b. Visual-Motor Development
   Stringing of Beads
   Maze Tracing
   Maze Cutting
   Copying of Forms
   Copying Letters of Name
   Form Discrimination
   Letter Discrimination

c. Gross Motor Development
   Coordination
   Agility
   Balance

d. Language-Speech Development
   Speech Maturity
   Language Maturity

e. Social-Emotional Development
   Social-Emotional Maturity

f. Work Skills
   Cooperation
   Attention Span

4. A numerical value of zero to four was assigned to the child's performance on each subtest of the rating scale.

E. Staff Responsibility in Screening

All staff members were responsible for observing and making notes in all areas of the evaluation. Staff members were also assigned specific areas of responsibility. 1. The Kindergarten Teachers were concerned mainly with the areas of Work Skills and Social Interaction, with observations concerning Basic Experience Skills, Visual-Motor Development, and Language Development. 2. The Elementary Principal was responsible for the evaluation in the area of Gross Motor Development. 3. The Elementary Counselor concentrated primarily on the areas of Basic Experience Skills, Visual-Motor Development, and Emotional Development. 4. The Speech Therapist's main area of concern was Language and Speech Development. 5. The School Nurse collected height, weight, medical and personal information.

F. Screening Procedures

1. The clinic was scheduled for the last week in April. The clinic was conducted similar to regular kindergarten classes. Half of the eligible children came in the morning and half came in the afternoon. The kindergarten teachers played much the same role as with the regular kindergarten class. They acted as a home base by having regular kindergarten activities for the children while the other staff members pulled the children out by groups in order to perform their evaluations.

2. Each of the home base rooms were divided into three color groups -- red, blue, and gold -- having six children in each group. Color tags with the child's name, address and bus assignments were made to identify students. Morning and afternoon sessions were scheduled on a twenty minute modular basis. Time was allowed for free play and snack break as care must be taken to avoid a rigid work schedule for this age child. Two groups of children are pulled out of each home base at the same time to work with one of the four special staff members in a specific skills area. Experience has shown us this method of scheduling works best because of the security the home base room provides.

3. At the end of the evaluation the separate ratings for the scale were added for each child and a total score was derived. Clinic notes and test scores were added to each child's file and rating sheet by the teacher aide.

4. The total score for all the children was placed on a continuum from highest to lowest. This continuum was used in the final staff meeting for reference to general ranking of the individual child. The rating scores were not the determining factor in special recommendation for a child. The most important factor was the fact of special needs identified by the staff during the clinic and agreed upon by all staff members during the final staff meeting. As an example, a child may have scored well on the total rating score and shown an overall good ability, but indicated a lack of security, poor social skills, or had poor attention span and still be recommended for a summer program.

G. Reporting to Parents and Follow-Up

1. Letters were sent to parents of all children following the staff meeting. Parents of children deemed ready for the regular program were informed by the staff of the results of the clinic indicating the student was ready to begin the regular kindergarten program in the fall. Parents of the other children received a letter requesting a conference. Individual conferences were held with the parents by the principal and counselor. The findings of the clinic and recommendations were explained to the parents. During the conference the purpose of the clinic was again explained and the philosophy of the school in starting the clinic. It was emphasized that we were trying to do the best for each individual child.

2. A six-week summer program was one of the alternatives the staff had available to them for placement of children with special needs. If the child attended the six-week summer program, an individual conference was again held with parents at the end of the program. The teachers also had individual conferences with the parents during the program if it was deemed necessary.

3. The total rating scale was administered again at the end of the summer school program for Title I evaluation purposes and to provide meaningful information to teachers for planning the kindergarten program.

BEST COPY AVAILABLE

Missouri
State
Department
of Education

"School success is born in the formative years of early childhood. Since learning begins at birth, we must foster the child's development long before he enters school."

Arthur F. Mallory
Commissioner of Education